STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155041	A. BUILDING 00 B. WING	11/30/2012

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NORTHWEST MANOR HEALTH CARE CENTER	6440 W 34TH ST INDIANAPOLIS, IN 46224

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F0000	This visit was for a Recertification and State Licensure survey. Survey dates: November 26, 27, 28, 29, and 30, 2012 Facility number: 000015 Provider number: 155041 AIM number: 100273750 Survey team: Janet Stanton, R.N.--Team Coordinator Heather Lay, R.N. Joyce Hofmann, R.N. Charles Stevenson, R.N. Brenda Nunan, R.N. Census bed type: SNF--6 SNF/NF--100 Total--106 Census payor type: Medicare--16 Medicaid--63 Other--27 Total--106 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.	F0000	This plan of correction is prepared and executed because of the provisions of State and federal law require it and not because Northwest Healthcare agrees with the allegations and citations listed. Northwest Health Care maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character so as to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance, that the alleged deficiencies cited have been or will be corrected by the date(s) indicated. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review 12/10/12 by Suzanne Williams, RN			

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F0156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on observation and interview, the facility failed to post the information about how to apply for and use Medicare and Medicaid benefits and how to receive funds. The deficient practice affected 106 of 106 residents residing in the facility. Findings include: On 11/29/12 at 10:00 A.M., environmental tour of the facility was initiated with the Administrator and the Maintenance Supervisor. At that time, the information regarding how to apply for and use Medicare and Medicaid benefits and how to receive funds was not observed. On 11/29/12 at 10:10 A.M., in an interview, the Administrator indicated	F0156	1. A Posting is now in place informing residents on how to apply for Medicare and Medicaid benefits. The posting is located by the main entrance to the facility and is visible to residents and visitors. 2. A Posting is now in place informing residents on how to apply for Medicare and Medicaid benefits. The posting is located by the main entrance to the facility and is visible to residents and visitors. 3. The Administrative staff have been in-serviced by the Administrator in regards to documnetation that needs to be posted for resident use. 4. The Administrator and/or designee will audit that the posting is in place on a weekly basis times 6 weeks and monthly times 5 months. The audits will be reviewed by the Quality Assurance Committee	12/30/2012

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	he was unaware information specific to Medicare and Medicaid needed to be posted since all residents were given the information in the facility admission packet. He indicated he had never posted the information. 3.1-4(l)(1) 3.1-4(l)(2)			

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F0167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to prominently display the results of the most recent survey and failed to post a sign designating where the survey results were located. The deficient practice affected 106 of 106 residents residing in the facility. Findings include: On 11/29/12 at 10:00 A.M., environmental tour was initiated with the Administrator and the Maintenance Supervisor. At that time, the facility survey results and a sign that indicated where to locate the survey results were not observed. On 11/29/12 at 10:10 A.M., in an interview, the Administrator indicated the survey book must have been	F0167	1. A posting is now in place informing residents on how to access survey results. The posting is located by the main entrance of the facility and is visable to residents and visitors. 2. A posting is now in place informing residents on how to access survey results. The posting is located by the main entrance of the facility and is visable to residents and visitors. 3. The Administrative staff have been inserviced by the Administrator in regards to documentation that needs to be posted for resident use. 4. The Administrator and/or designee will audit that the posting is in place on a weekly basis times 6 weeks and monthly times 5 months. The audits will be reviewed by the Quality Assurance Committee.	12/30/2012

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	moved. He also indicated the sign must have also been moved. He was not able to locate the survey book or the sign that indicated where the survey book was located. 3.1-3(b)(1)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure dignity was maintained for a resident (Resident #31) who was dressed only in a hospital gown throughout an entire day and was clearly visible from the adjacent hallway, and a resident (Resident #127) who had signs disclosing personal information posted on the wall of his room where they were visible from the adjacent hallway. This deficient practice affected 2 of 3 residents reviewed for dignity of 3 who met the criteria for dignity. Findings include: 1. The record of Resident #127 was reviewed on 11/30/12 at 11:00 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia, gastro esophageal reflux disease, and neurogenic bladder. A quarterly Minimum Data Set (M.D.S.) assessment dated 8/27/12	F0241	1. Resident 127's care plan was revised to reflect the wishes of the resident/POA having signage posted in the residents room. Education has been provided to ensure that resident /POA understands those revisions. Resident 31's care plan has been revised to reflect the wishes of the residents right to refuse care and education has been provided to ensure that the resident/POA understands those revisions. 2. All residents care plans have been reviewed and revised as necessary to reflect the wishes of the resident/POA and education has been provided to ensure that the resident/POA understands those revisions. 3. Staff has been in-serviced by the Director of Nursing and/or designee on dignity/privacy. On-going education will be provided for non-compliance and new employee orientation by nursing administration. 4. Nursing administration will conduct a dignity/privacy audit weekly times 6 weeks and monthly times times 5 months. The audits will be reviewed by the Quality Assurance Committee	12/30/2012

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	indicated Resident #127 was cognitively impaired, required extensive to total assist with all activities of daily living, and did not ambulate. During observations on 11/27/2012 at 2:45 P.M. and again on 11/30/12 at 11:40 a.m., signs were noted on the wall above Resident #127's bed, one stating the resident was always to have an undershirt on, and the other that he was to always have support behind his neck and under his arm. One sign was signed by the resident's wife. The signs were visible from the hallway. Resident #127's record contained no documentation the facility had discussed the placement of these signs with Resident #127's wife, including but not limited to the possible effect to Resident #127's dignity by the disclosure of personal information, alternatives including communicating with staff which would eliminate the need for the signs, or placing the signs in a location where they were not visible from the hallway. During an interview on 11/30/12 at 11:45 a.m. the Unit 2 Nursing Manager indicated that the resident's wife had placed the signs, and had			

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	told her that she wanted the signs to remain up. The Unit Manager indicated she had no documentation of any communication between the facility and Resident #127's wife concerning the placement of the signs, including discussing any alternatives to placing the signs where they were visible to staff, other residents, and visitors. 2. An undated facility document titled "Resident Rights-Federal," received from the Administrator on 11/30/12 at 4:15 p.m., indicated "Privacy and confidentiality: The Resident has the right to personal privacy...Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits and meetings of family and resident groups..." During an interview on 11/30/12 at 4:15 p.m. the Administrator indicated the facility had no additional policy or procedure addressing the issue of maintaining resident dignity. 3. During observations on 11/26/12 between 10:00 A.M. and 3:30 P.M., Resident #31 was lying in bed wearing a hospital gown. The resident's door was open and the resident was visible from the hallway.			

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	During observations on 11/27/12 between 8:30 A.M. and 3:30 P.M., Resident #31 was lying in bed wearing a hospital gown. The resident's door was open and the resident was visible from the hallway. On 11/28/12 at 8:15 A.M., Resident #31 was observed from the hallway sitting in bed with the head of the bed elevated. The resident was dressed in a hospital gown. During observations on 11/28/12 at 11:30 A.M., Resident #31 was lying in bed, dressed in pink pajamas. The resident was visible from the hallway. During an observation on 11/29/12 at 9:15 A.M., Resident #31 was lying in bed dressed in a hospital gown. The resident's door was open and the privacy curtain was pulled back, allowing her to be seen dressed in the hospital gown from the hallway. During an interview on 11/29/12 at 10:06 A.M., C.N.A. #33 indicated Resident #31 was "usually dressed." he indicated the resident easily became cold and preferred being dressed in warm clothing. He stated "not sure" why the resident was not dressed during observations on 11/26 and 11/27/12.			

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	During an interview on 11/29/12 at 10:14 A.M., C.N.A. #34 stated "[Resident #31] gets cold and is usually dressed in sweat suits." The C.N.A. indicated she didn't know why the resident was not dressed during the observations on 11/26 and 11/27/12. The C.N.A. indicated the resident was normally dressed by 10:00 A.M. During an interview on 11/29/12 at 10:20 A.M., R.N. #35 indicated Resident #31 should have been dressed daily. She indicated the resident was sometimes combative and resisted care. The clinical record for Resident #31 was reviewed on 11/30/12 at 3:14 P.M. Diagnoses included, but were not limited to, dementia, depression and hallucinations. A Care Plan, updated 10/21/12, indicated Resident #31 required staff assistance for ADLs [Activities of Daily Living]. One approach/intervention indicated "... Dress in appropriate clothes daily...." 3.1-3(t)			

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F0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure an individualized program of activities was provided to 1 of 3 residents reviewed for activities, in a sample of 10 residents who met the criteria for activities. [Resident #19] Findings include: On 11/28/12 at 9:19 A.M., Resident #19 was observed sitting in a wheelchair in his room. The TV was on and turned to the "QVC" channel. The resident indicated he did not watch TV. He also indicated there really wasn't much of anything he wanted to do. There was a "Checkers" game (in a box) on his night stand. The resident indicated he doesn't play checkers. On 11/28/12 at 10:11 A.M., the resident was observed to be in his room in bed. The T.V. was still turned on to the "QVC" channel. At that time, devotions, news, and exercises	F0248	1. Resident 19's activity care plan revised to reflect his current activity interest. 2. All residents had their activities care plans reviewed and revised as necessary to reflect current activities interest. 3.Activities staff have been in-serviced by the Activities Director on Resident Activities Policy and Procedure. On-going education will be provided for non-compliance and new employee orientation by the Activities Director and/or Designee. 4. Activities Director and/or designee will conduct an audit of resident's activity care plan weekly times 6 weeks and monthly times 5 months. The audits will be reviewed by the Quality Assurance Committee	12/30/2012

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	were scheduled as group activities in the main dining room. At 10:45 AM, the resident was observed to be in his room in bed. On 11/28/12 at 11:15 AM., the Assistant Activity Director was observed gathering residents into the main dining for exercises. The resident was in bed, with a visitor sitting beside him. On 11/28/12 at 1:25 PM, the resident was observed sitting in his wheelchair in his room by himself. On 11/29/12 at 8:50 A.M., C.N.A. #41 was observed in the resident's room. She was asking him if he wanted to lay down or watch TV. The resident requested TV. The C.N.A. tried to turn the channel but was having trouble with the remote control. She told the resident she would need to get someone to fix it. In an interview on 11/29/12 at 8:57 A.M., C.N.A. #41 indicated the resident liked to watch "Matlock" on T.V., and liked to go to exercises. She tells him what is scheduled as far as group activities in dining room. She indicated he needed to be encouraged to go to other activities.			

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	On 11/29/12 at 10:17 AM, the resident was observed in bed. The TV was off. A large group activity was being conducted in the main dining room, with Christmas music and coffee. The clinical record for Resident #19 was reviewed on 11/28/12 at 9:45 A.M. Diagnoses included, but were not limited to, altered mental status, diabetes, hypertension, chronic kidney disease, dementia without behavior disturbance, and depressive disorder. A "Psychotropic Medication Evaluation" form, with evaluation dates of 7/17 and 8/30/12, indicated the resident had been on Remeron and Zoloft [antidepressant medications]. On 11/8/12, the Zoloft was discontinued and Celexa [an antidepressant medication] was started. A Social Service progress note, dated 11/8/12, indicated "... spoke with [family members] regarding recent inappropriate sexual behaviors. ...explained that Depakote medicine had been discontinued and the doctor didn't think the behaviors were related to this medication, but related to dementia and depression. He is on			

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	Celexa [an antidepressant] now." A "Geriatric Depression Scale" was done on 1/13/12. The resident scored a "9" (greater than 5=probable depression). A current depression scale test was not found. An "Activity Evaluation," completed on 11/14/12, indicated the resident had past interests of card games [Wisk, 5-Up, Spades], Checkers, wood projects, cooking, trips, gardening, fishing, church volunteer work, community outings, groups/organizations. Current interests were identified as exercise, basketball, Rock & Roll "oldies' music, spending time outdoors, watching all kinds of game shows and news on T.V., action movies, and parties/social events. Care Plan entries and interventions included, but were not limited to, the following: 11/20/12--Problem: At risk for re-occurring depressive symptoms related to diagnosis of depression, currently controlled with antidepressant medication... Approaches: ... Encourage participation in social activities of			

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	choice.... 11/20/12--Problem: At risk for elopement related to dementia and exit seeking behavior... Approaches: ... Monitor for times when exit seeking is more prevalent; Involve in activity of choice especially during periods of increased exit seeking; assess for causes of exit seeking, i.e. going home, looking for someone/something, food/fluids, bathroom.... 11/14/12--Problem: Resident has previous recreational interests/patterns--Involved in group activities such as exercise, music, food-related church activities. Approaches: Introduce to other residents with similar interests, disabilities, and/or limitations; Obtain prior level of activity involvement and interests by talking with resident, staff, family; Consider impact of medical problems on activity level; Explain importance of social interaction, leisure activity time; Invited to scheduled activities; Offer variety of activity types and locations; Invite/encourage family members to attend activities with resident; Remind resident that they may leave activities			

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	at any time, and is not required to stay for entire activity; Likes food related activities; Is a people watcher. In an interview on 11/30/12 at 11:24 A.M., the Activity Director indicated they invite the resident to the group activities, but he often refuses. She indicated he likes to come to some activities that involve food, but he will not stay. She indicated the resident likes to sit at the door and watch people. An "Activity Progress Notes" entry, dated 11/14/12, indicated "... he tends to stay to himself. He uses a wheelchair for mobility. Has some interest in exercises, sports (basketball), music (Rock & Roll) oldies. He has attended church at times. He watches game shows and news. He also watches action movies. He will talk to you if you talk to him... he tends to stay close to his room and in the hallway...." An undated "Resident Activities Policies" was provided by the Director of Nursing on 11/30/12 at 2:45 PM., and included, but was not limited to, the following information: "1. OBJECTIVES: a. To encourage all residents to exercise their abilities.			

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	b. To meet the individual needs of our residents through a planned resident activity program. c. To incorporate resident activities in total resident care plan. d. to provide physical, intellectual, social, and emotional challenges much in the same way that everyday life in the community provides.... 5. ACTIVITY PROGRAM: a. The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident. 3.1-33(a)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a health care plan for 1 resident with swallowing difficulties (Resident #127) and failed to develop an integrated health care plan for 1 resident (Resident # 31) receiving hospice services; in a sample of 40 residents reviewed for Care Plans. Findings include: 1. The record of Resident #127 was reviewed on 11/30/12 at 11:00 a.m.	F0279	1. Resident 127's care plan was updated to reflect swallowing difficulties. Resident 31 is not currently under Hospice Services Residents 7's care plan was updated to show integration between nursing and Hospice 2. All residents at risk for swallowing difficulties had care plans reviewed and updated as indicated. All residents receiving Hospice services had care plans reviewed and integrated as indicated. 3.Staff members involved in creating care plans has been in-serviced by the Director of Nursing and/or designee on integrating the	12/30/2012

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	Diagnoses included, but were not limited to, Parkinson's disease, dementia, gastro esophageal reflux disease, and neurogenic bladder. A quarterly Minimum Data Set (M.D.S.) assessment, dated 8/27/12, indicated Resident #127 was cognitively impaired, required extensive to total assist with all activities of daily living, did not ambulate, required assistance with eating, had a diagnosis of dysphagia (swallowing difficulties), and his nutritional status included difficulty swallowing. During an interview with Resident #127's wife on 11/27/2012 at 2:28 P.M., she indicated the resident had ongoing problems with swallowing. Records indicate she has been his Health Care Power of Attorney since June 26, 2009. Social Service Progress notes indicated: 8/27/12 "...is fed by staff..." 11/12/12 "...needs total care...comes to MDR (main dining room) where staff feed him..." 11/26/12 "Significant (symbol for		hospice care plan and care planning swallowing difficulties. On-going education will be provided for non-compliance and new employee orientation by the nursing administration. 4. An audit will be conducted for residents with swallowing difficulties by Director of Nursing and/or designee to ensure care plans are in place weekly times 6 weeks and monthly times 5 months. The audits will be reviewed by the Quality Assurance Committee.	

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	"change") assessment:..he needs assist (symbol for "with") all care..." A Dietary Review dated 11/26/12, noted Resident #127 was fed by staff, and was on a pureed diet secondary swallowing issues. A physician's order dated 11/27/12, indicated a change to honey thickened liquids. Records indicated that prior to this change, Resident #127 was on regular liquids. A Speech Therapy "Plan of Care" dated 11/27/12, following his change to honey thickened liquids, indicated an onset date of 2/12/2011 for Resident #127's swallowing difficulties, and a treatment diagnosis of dysphagia (difficulty swallowing). A short term goal was "The patient will safely swallow 1 tsp (teaspoon) of thin liquid..." and a long term outcome was "Resident to tolerate least restrictive diet without overt S/S (signs or symptoms) of aspiration." During an interview on 11/30/12 12:05 p.m., the Therapy Director indicated Resident #127 had been evaluated on 11/27/12 for swallowing difficulties secondary to his change to a honey thickened liquid diet and a treatment diagnosis of dysphagia,			

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	and that he had no speech therapy plan of care prior to that date. Resident #127's record contained no comprehensive care plan for swallowing difficulties. During an interview with the MDS coordinator on 11/30/12 at 11:30 a.m., she indicated there was no health care plan for Resident #127 for swallowing difficulties. A facility document dated 10/2011, received from the Administrator on 11/30/12 at 4:15 p.m. and indicated to be the facility's policy and procedure for health care planning, indicated in its entirety: " Policy/Procedure: Care plans for residents. Purpose: Provide guide for resident care to disciplines. Care plans will be implemented based on areas identified through assessment. Actual or potential problems problems may be addressed. All disciplines will implement care plans as needed through the			

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	assessment process. Care plans will be reviewed and revised as needed." 2. On 11/30/12 at 2:05 P.M., Resident #7's record was reviewed. Diagnoses included, but were not limited to, acute renal failure, anemia from kidney disease, hypertension, and osteopenia. A physician's orders, dated 10/24/12, indicated the resident was admitted to hospice with the diagnosis of debility. A care plan, dated 10/24/12, included, but was not limited to, "I have chosen to receive hospice care... related diagnosis: Chronic Kidney Disease... goal: I will remain comfortable throughout hospice care... approaches: coordinate my care with my hospice team, coordinate with the hospice team to assure I experience as little pain as possible, provide me and my family with grief and spiritual counseling if desired..." The hospice agency "Hospice Certification and Plan of Treatment," dated 10/24/12, included, but was not limited to, "Goals: to assist with pain control and symptom management. Provide support to patient and family..."			

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	On 11/30/12 at 2:33 P.M., in an interview, RN #23 indicated that Resident #7 did not have a coordinated hospice care plan. She indicated the facility had care plans and the hospice agency had a plan of care [Hospice Certification and Plan of Treatment]. She indicated that hospice will notify the facility when the nurse or aides are coming for a visit so that services, such as a bath, are not duplicated for that day. 3.1-35(a)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure physician's orders for pain medication for 1 resident (Resident #120) were followed; and Care Plan interventions for 1 resident who had behaviors (Resident #31) were implemented; in a sample of 40 residents reviewed for care plans. Findings include: 1. On 11/27/12 from 10:23 A.M. to 11:30 A.M., Resident #31 was observed in her room, in bed, yelling, "Hey, Hey, Hey...," as staff members passed by her room. No staff member attended to the resident over the hour. On 11/29/12 at 10:20 A.M., in an interview, the Assistant Director of Nursing indicated that when Resident #31 was taken out of her room, she would have a foul mouth and be combative at times. Therefore, the Assistant Director of Nursing indicated Resident #31 did not come out of her room often.	F0282	1. Resident 120's medication was reviewed to ensure availability. Resident 31's behavior care plan has been reviewed and updated as indicated. 2. All residents that choose to use a pharamacy other than the facilities will be educated on the requirements of that choice. All residents with behaviors will have care plans reviewed and updated as indicated. 3. Nursing staff have been in-serviced by the Director of Nursing and/or designee on Medication Avalibility. On-going education will be provided for non-compliance and new employee orientation by the nursing administration. 4. Audit will be conducted on residents medication availability weekly times 6 weeks and monthly times 5 months. The audits will be reviewed by the Quality Assurance Committee.	12/30/2012

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On 11/29/12 at 11:05 A.M., Resident #31's record was reviewed. Diagnoses included, but were not limited to, hypothyroidism, osteoporosis, dementia, history of urinary tract infection, anemia, depression, sensory hearing loss, and psychosis.

A care plan, dated 9/25/12, included, but was not limited to, "Problem: May become agitated and curse and repeat herself, may resist care... Goal: Will have no decline in mood or distress... Approach: Cue and remind as needed, daily interactions, provide emotional support, allow her time to express feelings, anticipate needs, observe for pain, 1:1 visits..."

The facility failed to assess Resident #31's needs over a one hour time period when observed on 11/27/12.

2. On 11/28/12 at 2:00 P.M., Resident #120's record was reviewed. Diagnoses included, but were not limited to, non-Alzheimer's dementia, depression, hepatic encephalopathy, and pain.

A "Medication Administration Record" dated 10/2012, indicated the scheduled doses of

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	Hydrocodone/APAP 7.5/325 give 1 by mouth 2 times per day [order date of 7/26/12] were not given on 10/27/12, 10/28/12, and 10/29/12 related to not being available from the pharmacy. Therefore, the resident did not receive his scheduled pain medication for 3 days. There was no documentation in the record regarding a pain assessment for 10/27/12, 10/28/12, or 10/29/12 and there was no documentation of Resident #120's physician being notified regarding the pain medication being unavailable. A "Pain" care plan, dated 11/6/12, included, but was not limited to, "Pain related to space in left knee: Assess pain level every shift, comfort measures, repositioning, medicate for pain as needed, assess effectiveness of pain med's, encourage participation in activities of choice daily, report changes in pain... 11/25/12: increase Norco related to increase in pain...." On 11/28/12 at 3:05 P.M., in an interview, LPN #24 indicated a pain assessment was not completed daily for a resident who received scheduled pain medications. At that time, LPN #24 could not provide pain			

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	assessments for Resident #120 on 10/27/12, 10/28/12, and 10/29/12 [the days his pain medication was unavailable]. She indicated that Resident #120 used a mail order system for his medications and on those days his medication was out. She indicated that since he was not complaining of pain, pain medication was not removed from the facility's emergency drug kit. However, LPN #24 was unable to provide a pain assessment for Resident #120 on 10/27/12, 10/28/12, and 10/29/12. On 11/30/12 at 9:30 A.M., the Administrator provided "General Guidelines for Medication Administration and Special Deliveries" policies and procedures, dated 2005. The policies and procedures included, but were not limited to, "If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time... the physician is notified... Special Deliveries... Medications that must be delivered before the next scheduled delivery due to a resident's immediate need should be faxed to the pharmacy... The pharmacist will determine the appropriate manner by which to obtain the medication... The EDK [emergency drug kit] may be			

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	utilized... the back up pharmacy may be called by pharmacy... the pharmacy may send a special driver..." 3.1-35(g)(2)			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure pressure prevention devices were properly used to prevent a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers, in a sample of 3 residents who met the criteria for stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) or stage 4 (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcers (Resident #50). Findings include:	F0314	1. Resident 50's cushion was replaced and care plan updated as indicated 2. Residents at risk for pressure ulcers safety devices were reviewed and changed as indicated. Care plans were updated as indicated. 3. Nursing staff has been in-serviced by the Director of Nursing and/or designee on pressure ulcer prevention policies and procedures. On-going education will be provided for non-compliance and new employee orientation by the nursing administration. 4. An audit will be conducted on residents with pressure releaving/reducing cushions weekly times 6 weeks and monthly times 5 months. These audits will be conducted on various shifts throughout the auditing period. The audits will be reviewed by the Quality Assurance Committee.	12/30/2012

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	During observations on 11/28/2012 at 9:18 A.M., CNA #35 transferred Resident #50 from the wheelchair to the toilet. The resident was transferred back to her wheelchair and sat on a deflated waffle cushion (pressure prevention cushion) that had a ½ inch cloth covered pad placed on top of the cushion. During observations on 11/28/12 at 9:57 A.M., Resident #50 rolled her wheelchair into hallway. The waffle cushion she sat on was deflated. During observation on 11/28/12 at 10:43 A.M., CNA #35 and RN #36 assisted Resident #50 with a transfer from the wheelchair to the toilet. The resident was transferred back to her wheelchair and sat on a deflated waffle cushion. During an observation on 11/28/2012 at 10:56 A.M., the Activities Director assisted Resident #50 to the dining table for a cup of tea. Resident #50 was seated in her wheelchair on a deflated waffle cushion. During an interview on 11/28/2012 at 12:58 P.M., CNA #35 indicated the waffle cushion should be checked frequently to be sure it is inflated. She indicated she was not aware the			

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	cushion was deflated when she transferred Resident #50 to the commode and returned her to the wheelchair at 10:43 A.M. During an interview on 11/28/2012 at 1:09 P.M., CNA #33 stated "[Resident #50's] waffle seat cushion may need to be pumped up." He indicated the level of inflation was determined by the resident's position or complaints of discomfort. During an interview on 11/28/2012 at 1:20 P.M., LPN #38 stated Resident #50 had a cushion in her chair and her position was supposed to be "shifted in the chair every couple of hours," when asked if there were specific interventions in regard to the pressure reducing cushion. During an interview on 11/28/2012 at 1:25 P.M., RN #39 indicated Resident #50's pressure reducing interventions were, "to keep the resident clean and dry and toileting." During observations on 11/28/2012 at 1:57 P.M., RN #37 provided wound care to Resident #50's right posterior thigh. The wound center was red and had a medium amount of serous drainage wiped from the wound. The wound bed was granulating and red.			

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	The skin surrounding the wound bed was pink, dry and scaling. RN #37 did not measure the wound but stated, "The wound has depth." A wound measurement documented on 11/26/2012 indicated, "...1.5 cm (length) X (by) 1.0 cm (width) X 0.2 cm (depth)...." During an interview on 11/28/2012 at 1:57 P.M., RN #37 stated the wound on Resident #50's right posterior thigh "was a result of sitting on the Roho (a wheelchair cushion used to relieve pressure) cushion valve." She indicated the resident had not used a Roho cushion since the wound occurred. RN #37 indicated the resident used a waffle or gel cushion for pressure relief after the open wound was discovered. The RN stated she "did not recall" who notified her of the resident's open wound on her right thigh. The RN stated, "the cushion was deflated and all balled up and under [Resident #50]," when she assessed Resident #50's right posterior thigh wound on 10/03/2012. During an interview on 11/28/2012 at 2 25 P.M., the Unit Manager indicated a Roho cushion had not been placed in Resident #50's wheelchair since discovering the open wound to the			

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	right posterior thigh. She stated, "The cushion valve caused the injury." The Unit Manager stated, "The cushion shifted in the chair, creating an opportunity for the valve to push against the resident's skin." During an interview on 11/28/2012 at 3 32 P.M., OT (Occupational Therapist) #40, indicated Resident #50's Roho cushion had been discontinued per nursing. OT #40 indicated the Roho cushion valve should have gone out the back of the resident's chair and should have been positioned so the valve pointed downward to prevent the resident from sitting on the valve. During an interview on 11/28/2012 at 3:54 P.M., the DoN indicated there was not a specific method for applying a Roho cushion in a wheelchair. She stated, "You just lay the (Roho) cushions on the chair." During an interview on 11/30/12 at 8:45 A.M., the DoN indicated Resident #50 should not have been sitting on a deflated cushion. Resident #50's record was reviewed on 11/28/2012 at 9:48 A.M. Diagnoses included, but were not limited to, cerebral vascular accident			

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	(stroke), degenerative joint disease, osteoarthritis, hypertension (high blood pressure), schizoaffective disorder, dementia, right lung nodule, obesity, obstructive sleep apnea, diabetes mellitus, type II (adult onset diabetes) and non-stageable posterior thigh pressure ulcer. A pressure ulcer risk assessment, dated 5/25/12, indicated a score of 19, indicating Resident #50 had a high risk for pressure wounds. The MARs (Medications Administration Records), dated September 2012 and October 2012, indicated, "...WEEKLY HEAD TO TOE SKIN ASSESSMENT...." The MARs indicated skin assessments were completed on the 7th, 14th, 21st, and 28th of each month. The 10/07/2012 documentation indicated, "...open area to back of (R) (right) thigh...." The record did not indicate an open area to the right thigh prior to 10/07/2012. During an interview on 11/28/12 at 2:55 P.M., the DoN (Director of Nursing) indicated the nurses make the rounds for weekly skin assessments and only document if there is a problem.			

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	A "wound" record, dated 10/03/2012, indicated a NS (non-stageable [Unstageable - Pressure ulcer is known but not stageable due to non-removable dressing/device or due to the coverage of the wound bed by slough or eschar]) wound measuring 6.0 cm (centimeters) in length by 5.0 cm in width and NS depth with medium amount of serous (pale yellow and transparent) drainage. The record indicated the wound bed was red with necrosis (dead) and slough (shedding of skin) and the color was 10% (percent) black, 20% yellow-green and 70 % red. A physician's telephone order, dated 10/3/12, indicated, "...Clean area on R (right) upper thigh (inferior) with N/S (normal saline). Apply skin prep to wound perimeter. Santyl (therapy that removes necrotic tissue from wounds) Oint (ointment) to wound bed, cover (with) calcium alginate (wound dressing). Apply protective dressing qd (every day)...." An "Acute Care Plan," dated 10/3/12, indicated "Open area inner rt (right) thigh...." Interventions indicated, "...Check w/c (wheelchair) cushion freq (frequently) for inflation/position...."			

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A "Geriatric Subsequent Visit Form," dated 10/4/12, indicated, "(R) post thigh (with) ulcer (with) min slough surrounding nonblan (non blanch) erythemia (redness)... (1) Pressure Ulcer thigh; due to w/c. Cushion replaced. Encouraging pt to get into bed QHS (every bedtime) (has always refused but did get in bed last nt [night]). Santyl & local wound care...."

A Care plan, dated 10/05/2012, indicated, "...a potential for skin breakdown r/t (related to) decreased mobility, incontinence, DM (diabetes mellitus), Obesity...Pressure reducing surface to chair/bed...Check w/c cushion frequently for proper inflation & position...."

The annual MDS (Minimum Data Set) assessment, dated 10/02/2012, indicated a BIMS (Brief Interview of Mental Status) score of 15, indicating the resident was cognitively alert.

An undated policy/procedure, titled "PRESSURE ULCER RISK ASSESSMENT," indicated, "...IDENTIFY RESIDENTS AT RISK FOR PRESSURE ULCER DEVELOPMENT AND IMPLEMENT APPROPRIATED INTERVENTIONS, PRESSURE ULCER RISK TO BE

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	COMPLETED OR ADMISSION, QUARTERLY AND WITH SIGNIFICANT CHANGE...." An undated policy, titled, "SKIN PREVENTION INTERVENTIONS," indicated, '...PRESSURE ULCER RISK IDENTIFIED, CARE PLAN WITH INTERVENTIONS BASED ON ASSESSMENT, WEEKLY SKIN ASSESSMENTS...." 3.1-40(a)(1)			

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F0323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview, and record review, the facility failed to ensure a resident's alarm alert was in place and functioning to prevent multiple falls and failed to provide supervision to prevent multiple falls for 1 of 3 residents reviewed for falls in a sample of 7 residents who met the criteria for falls. [Resident #188] B. Based on observation, record review and interview, the facility failed to ensure the resident environment remained free of potential hazards related to razors and a metal hanger with sharp ends exposed. The deficient practice had the potential to affect 2 residents [Residents #13 and #180] observed during the environmental tour. In addition, the facility failed to secure chemical hand sanitizer on 1 of 3 halls [200 hall], potentially affecting 41 residents residing on that hall. Findings include: A.1. Clinical record review for	F0323	1. Resident 188's alarms are in place and functioning The razor, metal hanger and hand sanitizer were removed. 2. All residetns with alarms in place were reviewed to ensure alarms were in place and functioning. All resident areas were checked and no other razors, metal hangers or hand sanitizer were found. 3. Staff have been in-serviced by the Director of Nursing and/or designee on Safety policy and procedures in regards to sharps items and chemical storage. Nursing staff were in-serviced on alarms being in place and functioning on beds and wheel chairs. On-going education will be provided for non-compliance and new employee orientation by the nursing administration. 4. Audits will be conducted by Director of Nursing and/or designee on all residents with alarms to ensure that they are in place and functioning weekly times 6 weeks and monthly times 5 months. Audits will be conducted by the Housekeeping Supervisor and/or designee in resident areas to ensure no safety hazards exist weekly times 6 weeks and monthly times 5	12/30/2012

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	Resident #188 on 11/29/12 at 10:02 A.M. indicated in the Physician Progress Notes dated 8/17/12, the resident was admitted from a medical center status post falls, cerebrovascular accident [CVA] with right sided weakness, and dementia, and was admitted for rehab and assist care. The notes indicated the resident used a walker, but was now unable to hold onto it. The notes indicated two previous falls at home which were unwitnessed. The clinical record indicated diagnoses which included, but were not limited to, history of personal falls at home, cerebrovascular accident, myocardial infarction, osteoarthritis, Alzheimer's disease, diabetes, coronary artery disease, and advanced dementia. Review of Resident #188's admission Minimum Data Set [MDS] assessment dated 08/23/12, indicated the resident had falls at home, but none since admission. The MDS assessment indicated a BIMS [brief interview for mental status] score of "7" which indicated the resident was severely cognitively impaired with daily decision making skills. The MDS assessment indicated the resident needed extensive assist with		months. The audits will be reviewed by the Quality Assurance Committee.	

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	bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. The assessment indicated the resident had changes in incontinence and was frequently incontinent of bowel and bladder and had a fall risk scored at "14," which indicated the resident was a high risk for falls. Nurse's Notes dated 8/23/12, indicated the resident "propels self in w/c [wheelchair]." Nurse's Notes dated 09/27/12 at 6:00 A.M., indicated, "Writer called to rm [room] by CNA, resident's alarm sounding d/t [due/to] res. [resident] attempting to ambulate to bathroom by self without assist, writer et [and] CNA attempted to help resident transfer, however, res. became very unstable et was lowered to floor softly, no injury, no change in condition of skin, no s/s [sign/symptoms] of fx [fracture], controlled fall, lowered to floor x [times] 2 person assist - faxed to MD [Medical Doctor], left message for call back with res. spouse (responsible party) [sic], will f/u [follow up] c [with] oncoming shift to monitor for any changes, vs [vital signs]: BP [blood pressure] 157/86, p [pulse] 73, r [respirations] 20, t [temperature] 97.6, sats 99% ra [room air] res. assessed			

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	for injuries transferred back to bed, alarm in place et functioning properly res. requires frq [frequent] reminders on call bell to ask for assistance, will cont. [continue] to monitor call bell in reach." Nurse's Notes dated 09/27/12 at 5:30 P.M., indicated the staff had spoke with the physician regarding resident's complaint of lower back pain and new order was noted. The notes indicated "no injuries noted, relief noted after receiving Tylenol, bed/chair alarms in place and functioning will cont. [continue] to monitor." Nurse's Notes dated 09/28/12 at 6 P.M. indicated, "grimacing noted c/o lower back pain received Tylenol per order c relief noted. No injuries noted bed/chair alarm in place and functioning." Nurse's Notes dated 10/04/12 at 9:30 A.M. indicated, "CNA called nurse into res. room. Res found on floor, incontinent of bowels lying on lt [left] side across from bathroom door. w/c [Wheelchair] inside bathroom. Res. was wearing gown and no shoes or socks. v/s 115/85, 102, 20, 97.9, o2 sat 96% on ra [room air]. Message left for family to call facility. MD informed. Day nurse initiated neuro			

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	checks. Will cont. to monitor. Will initiate toileting program and educate staff." Documentation was lacking if the alarm was sounding to alert staff. Nurse's Notes dated 10/24/12 at 6:40 A.M. indicated, "Heard res. pushing something around in rm. [room] As entered rm. res was falling to floor, landed on buttocks in front of w/c. Did not hit head. Noted pea-sized abrasion to (L) [Left] side of knee, area red ROM [range of motion] wnl [within normal limits]. Res. states he was trying to go to bathroom. V/S 155/91 - 92 - 20 - 97.6. Dr. _____ [name of physician] notified informed of fall c no apparent injuries. _____[name of daughter] - daug also notified. Will report oncoming nurse for F/U [follow-up]." Documentation was lacking in regards if the alarm was sounding to alert staff. Nurse's Notes dated 11/4/12 at 4:30 p.m. indicated, "Res states he forgot he couldn't walk without assist, walked to bathroom, lost balance fell backward, denies hitting head, no signs /symptoms of evidence head hit. No injuries noted, denies pain, @ [at] first a little shook up from fall, states he was quite superized [sic]. Res re-oriented to call light and need			

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	to ask for assist pull tab on w/c replaced with cushion pressure alarm." Documentation was lacking in regards if the alarm was sounding to alert staff. Physician Telephone Orders indicated the following: 8/17/12 - "Skilled PT [Physical Therapy] 6 x [times] / [per] wk. [week] for 8 wks [weeks] to ...." 8/29/12 - "dc Discontinue] risperdal" 8/31/12 - "no cpr [cardiopulmonary resuscitation]" 9/13/12 - "Skilled ST services discontinued. Resident has reached maximum potential." 9/25/12 - "D/C skilled PT/OT services. D/C to RNA [restorative nurse aide] for amb. [ambulation] and stretching to bil [bilateral] hams [hamstrings]." 11/12/12 - "Maintain bed / chair alarm at all times check placement of alarms q [every] shift" 11/13/12 - "PT/OT/ST to screen d/t [due/to] functional decline, cognitive decline" 11/18/12 - "PT to eval & tx [treat] as indicated. PT clarification order: PT 5 x / wk for 4 wks for thera [therapeutic] ex [exercises], thera. act [activity], DMR and modalities." Resident #188's care plans were reviewed 11/29/12 at 2:45 P.M. and			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the following: Risk for falls/injury dated 8/28/12 with approaches of "maintain res. environment free of clutter and safety hazards, place items freq. [frequently] used by res. within easy reach, therapy , monitor for unsafe actions and intervene as needed. 9/27/12 safety teaching on use of call bell to request for assistance reeducation freq. [frequently] d/t [due to] inc. [increased] confusion, toileting program 10-4-12." Continued approaches dated 10/24/12 indicated, "maintain bed/chair alarm check functioning and placement q shift 10/24/12 - revision to toileting program; res. and specific staff education 11/4/12 - changed pull tab alarm to chair to pad alarm." Fall Risk assessments indicated the following dates and scores: 8/16/12 "14" 9/27/12 "16" 10/04/12 "16" 10/24/12 "16" 11/04/12 "17" 11/13/12 "17" Scores above 10 indicate a high risk for falls.			

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	155041	A. BUILDING 00 B. WING	11/30/2012

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	Resident #188 was observed on 11/29/12 at 1:40 P.M. during a transfer from wheelchair to bed by CNA #11. Interview with resident at this time when asked if he wanted to go to bed, he said, "I think so." Resident #188 was observed to be able to stand unsteadily with assist of one person and pivot to sit on his bed. During this transfer the wheelchair alarm was observed to sound when the resident went to standing position. CNA #11 indicated there was an alarm on bed, also. Resident #188 was observed on 11/29/12 at 1:55 P.M. to be in bed sleeping and CNA #12, the Restorative aide was asked to check the resident's bed alarm. The bed alarm failed to go off at first, but then made a couple of beeps. CNA #12 had Resident #188 to stand all the way up and the alarm was very slow to beep and beeped only a few beeps. Interview with Restorative aide, CNA 12, indicated this was not safe, and indicated the alarm has to fill with air then it will get louder, and she would reposition alarm to be further up in bed near the resident's back area so when the resident first starts to raise up the alarm would go off.			

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Interview with RN #13, unit manager, on 11/30/12 at 10:18 A.M., indicated the resident had no falls within the first 5 days of admission.

RN #13 indicated regarding the fall on 09/27/12, the resident was lowered to floor by 2 staff and the alarm was sounding. RN #13 indicated the CNA answered the alarm and called for assistance as res. was standing, was incontinent and on his way to bathroom. RN #13 indicated Resident #188 uses his call light on and off, but is not consistent. RN #13 indicated the intervention put into place at the time of this fall was teaching on the use of the call bell. RN #13 indicated no injury was noted with this fall and the resident was on therapy at the time until 09/25/12 and on 09/21/12 restorative was initiated for ROM and ambulation as the resident was no longer a candidate for therapy to pick back up.

RN #13 indicated regarding the fall on 10/04/12 at 9:30 A.M., the resident was found on floor by bathroom door, had been incontinent of bowel, had just finished breakfast, and had a big bowel movement, and was found between the foot of bed and the bathroom door. RN #13 indicated

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	she was not sure if the alarm was sounding, and indicated the resident had no injuries. RN #13 indicated the intervention was to start a toileting program to include the resident to be toileted after meals. RN #13 indicated regarding the fall on 10/24/12 at 6:40 A.M., the resident had gotten up before breakfast to go to bathroom and was found on floor. RN #13 indicated staff heard the resident pushing something around in his room. RN #13 was unable to identify the something, but thought it could have been the over the bed table. RN #13 indicated the resident initiated the fall when staff entered room, so the fall was witnessed, and the resident did not hit his head. RN #13 was unable to verify the alarm was sounding. The resident received a red abrasion to his left side of his knee and range of motion was within normal limits. RN #13 indicated the resident stated he got up to go to the bathroom. RN #13 indicated the intervention put into place was a revised toileting program to toilet the resident before and after meals and at bedtime and as needed. RN #13 indicated there was an alarm on bed - pad alarm, chair tab alert, and they changed the tab alert to pad			

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	alarm in the wheelchair. RN #13 indicated on the fall on 11/04/12 at 4:30 P.M. the resident was sitting in his wheelchair with tab alarm in place and the resident could remove the alarm and got up, went to bathroom, and was found on the floor in the bathroom with no injuries. RN #13 indicated the intervention put into place was the changing of the tab alarm to pad alarm. Interview with RN #13 on 11/30/12 at 12:04 P.M. indicated the alarm did not sound on the fall on 10/04/12 and alarmed on the other one in question. Interview with the DON 11/30/12 at 11:55 A.M. indicated the facility does have a restorative program for toileting if staff conclude the falls are around the resident trying to go to the bathroom. The DON indicated the toileting program was made up of an assessment, to see if the resident is mentally aware of the need to toilet and a 3 day voiding monitoring. During interview with the DON and Administrator on 11/30/12 at 1:10 P.M., when asked about the falls and if the alarms were functioning at the time of the falls, the DON and Administrator indicated the falls were			

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	part of their QA process and they do not share that information. When asked about the 3 day voiding pattern monitoring sheet for Resident #188, the DON and Administrator indicated they would look for it. Interview with Administrator on 11/30/12 at 1:30 P.M. indicated the alarm was sounding on one of the falls in October, but not the other fall and they could not locate the 3 day voiding pattern monitoring sheet for Resident #188. Review of the facility's most recent policy and procedure for Toileting Programs, dated 05/10/10, indicated, "Purpose: Reducing Episodes of Incontinence." The policy included a complete bladder data collection and assessment form to attempt to identify type of incontinence and the physical and mental ability to participate in a program. If the assessment shows potential then the facility implements the voiding pattern (a minimum of 3 days). The pattern if reviewed to identify periods when the resident is being found continent and a pattern can be identified. The facility will initiate the scheduled toileting program and educate staff on the toileting program. The facility will evaluate the effectiveness of the			

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	program and make changes to schedule if needed." Review of the facility's policy with no date, on Personal Alarms for Beds/Chairs, indicated the "Purpose: To alert care givers of resident unsafe movement. Prevent/Reduce fall related incidents." The policy indicated, "Personal bed/chair alarms will be utilized as one method of all prevention. Residents will be assessed and if determined appropriate will have an alarm placed. The staff will assess the effectiveness or ineffectiveness of the alarm. Alarms may be used for long term or short term depending on the resident medical, physical or mental status. Residents with alarm are to be monitored for increased agitation, anxiety, removal, or turning alarms off. IF the device is found to be ineffective it will be removed/discontinued. Alarms may be utilized at the nurses discretion for fall prevention, noting the interventions are monitored ongoing with changes made as needed. At a minimum the personal alarm intervention will be reviewed quarterly and with significant change in the resident condition. Nursing staff are responsible to ensure personal alarms are on and functioning."			

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	Review of the Manufacturer's recommendation for the bed/chair fall monitoring systems indicated the alarm pad should be place so that the bulk of the patient's weight (buttock area) will be resting on it. When the patient moves from the pad, the selected alarm tone sounds to remind the patient to sit or lay back down and alerts staff that a patient is at risk of falling. B.1. On 11/26/12 at 12:10 P.M., a bottle of hand gel [sanitizer] was observed on an unattended medication cart on the 200 unit hall. On 11/26/12 at 3:00 P.M., the bottle of hand gel [sanitizer] remained on the unattended medication cart. At that time, in an interview, RN #21 indicated the hand sanitizer was not hers; however, she would remove it from the medication cart. B.2. On 11/26/12 at 2:00 P.M., the restroom in Resident #180's room was observed. At that time, a wire hanger [that was taken apart with two sharp ends exposed] was observed hanging near the sink. In an interview, at that time, Resident #180 indicated he did not know what			

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	the hanger was used for, and the hanger was not his. B.3. On 11/27/12 at 10:00 A.M., the restroom in Resident #13's room was observed. Resident #13 shared the restroom with three other residents; however, those residents were unable to ambulate to the restroom without assistance. At that time, a disposal razor was observed on the ledge above the sink. On 11/27/12 at 10:10 A.M., in an interview, RN #22 indicated she would remove the razor and that she was aware it should not be left out. On 11/29/12 at 10:34 A.M., the Administrator provided a "Infectious Wastes Policy," no date. The policy included, but was not limited to, "To prevent the spread of disease and to maintain sanitation, the policy regarding disposal of infectious wastes shall be performed according to the following guidelines... Infectious wastes includes: Used sharps... The procedure for the disposal of the above is as follows: A puncture-proof, leak proof container has been placed in the medication room and on the medication cart... All used needles, syringes, and sharps			

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	shall be placed in the container for disposal..." On 11/29/12 at 10:34 A.M., the Administrator provided a "Material Safety Data Sheet," dated 8/28/12, for "Regimen Instant Hand Sanitizer." The "Material Safety Data Sheet" included, but was not limited to, "Potential Health Effects: Inhalation: may cause respiratory irritation, coughing, shortness of breath, nausea, dizziness, loss of coordination, drowsiness, loss of consciousness, and other symptoms of central nervous system depression... Highly flammable... Ingestion: Call for medical attention/help immediately..." 3.1-45(a)(1) 3.1-45(a)(2)			

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F0334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on record review and interview, the facility failed to immunize a resident with the influenza vaccine who signed consent to receive the vaccine. The deficient practice affected 1 of 5 residents reviewed for receipt of the influenza and pneumonia vaccine. [Resident #187] Findings include: On 11/27/12 at 3:00 P.M., Resident #187's record was reviewed for receipt of the influenza vaccine and pneumonia vaccine.	F0334	1. Resident 187 was given the flu vaccine. 2. All residents were reviewed to ensure that flu vaccines were offered and given per resident/POA consent. 3. Nursing staff have been in-serviced by the Director of Nursing and/or designee on Flu Vaccine policies and procedures. On-going education will be provided for non-compliance and new employee orientation by nursing administration. 4. Audits will be conducted by nursing administration on new residents admitted to the facility to ensure that Flu Vaccine was offered and given per resident/POA consent weekly times 6 weeks and	12/30/2012

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	A signed [by the resident's power of attorney] influenza consent was dated 9/21/12; however, there was no documentation of influenza vaccine being given. The pneumonia vaccine was given on 9/7/12 at a local hospital. On 11/29/12 at 10:00 A.M., in an interview, the Director of Nursing indicated all influenza vaccines were completed; however, the facility would provide residents with the influenza and pneumonia vaccines as needed. Regarding Resident #187, the Director of Nursing indicated her son was concerned that his mother had already received the influenza vaccine at a local hospital and requested that the facility check the status of the immunization prior to giving the vaccine on 9/21/12 [date of signed consent]. The Director of Nursing indicated she was not aware if the facility had followed up on Resident #187's influenza status and she would follow up to check if medical records found the information. On 11/30/12 at 9:30 A.M., the Director of Nursing indicated the resident had not received the		monthly times 5 months. The audits will be reviewed by the Quality Assurance Committee.	

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	influenza vaccine from the local hospital and the resident was given the vaccine on 11/29/12 per a physician's order. The facility failed to follow up on 9/21/12 as the son had requested. Therefore, Resident #187 did not receive the influenza vaccine for 2 months after consent was received. A "Influenza Vaccine" policy, dated 9/24/12, was provided by the Administrator on 11/26/12 at 11:00 A.M. The policy included, but was not limited to, "All residents will be offered the influenza vaccine annually... Residents may obtain their influenza vaccinations from their personal physicians. Documentation of previous vaccination should be provided to the facility..." 3.1-13(a)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure a sanitary environment for storing dry foods in 1 of 2 dry food storage areas and failed to ensure removal of expired food items from a food supply cart. This deficient practice effected 105 residents receiving nutrition from the main kitchen of 106 residents in the facility. Findings include: During the initial kitchen tour observations on 11/26/2012 between 9:25 A.M. and 10:05 A.M., a beverage in a plastic cup with a lid and straw, identified as belonging to Dietary Aide (DA) #1, was stored on a counter next to a tray of mixed fruit that was being prepared for resident consumption. A bowl of biscuits wrapped in plastic was stored on the counter furthest from the kitchen entry door without dates indicating when the items were prepared. Two packages of buns with expiration	F0371	1. The area identified during the survey was cleaned. The expired items were disposed of and no expired items were served to residents.The thermometer was removed, cleaned and sanitized per facility policy. 2. All areas of Dry food storage were observed to be clean and in sanitary condition No other food items were found to be expiredAll of the thermometers were cleaned and sanitized per facility policy. 3. All Dietary staff were inserviced by the Dietary Manager on cleaning of thermometers and Food Storage policies and procedures. On-going education of Food Storage and Cleaning of thermometers will be provided for non-compliance and new employee orientation by the Dietary Manager and/or designee. 4. Audit will be conducted on dry food storage areas weekly times 6 weeks and monthly times 5 months to ensure that areas are clean and expired food is disposed of properly.Audit will be conducted on cleaning of the themometers during 5 meal services per week for 6 weeks and 5 per month times 5 months.	12/30/2012

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	dates of November 18, 2012 and 3 packages of buns with expiration dates of November 25, 2012 were stored on a food cart in the kitchen. During an interview on 11/26/2012 at 9:55 A.M., the Dietary Manager (DM) indicated staff should not have stored a personal beverage next to food that would be served to residents. The DM indicated the biscuits were from the previous day's lunch and indicated the items would be thrown away. The DM indicated the outdated items should have been disposed of and threw the food in the trash. The dry food storage area, located in a building separate from the nursing facility, had dust/dirt/cobwebs on the floor near the edge of shelves where boxes of food were stored. A plastic container of liquid hand soap was stored on top of a box of canned pureed chicken. A plastic container of liquid hand soap was stored on top of a case of soda. During an interview on 11/26/2012 at 10:06 A.M., the DM indicated hand soap should not have been stored on top of food. She indicated the dry food storage area should have been cleaned weekly. The DM indicated she did not have a schedule for		The audits will be reviewed by the Quality Assurance Committee.	

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	cleaning assignments. During a second kitchen observation on 11/29/2012 at 7:20 A.M., Dietary Aide (DA) #32 placed a food thermometer in pureed sausage. The thermometer was cleaned by placing it under running water, then shaking excess water before putting into ground sausage. DA #32 repeated the aforementioned process for cleaning the thermometer 3 additional times when food temperatures for pureed eggs, scrambled eggs, and oatmeal were checked. During an interview on 11/29/2012 at 1:20 P.M., the DM indicated DA #32 should have used an alcohol swab to wipe the food thermometer after removing it from one food item and before placing it in the next food item. An undated facility policy, titled "Fight Bac! (sic) Concepts," indicated, "...Keep all storage areas clean....Label all food with the name and delivery date..." An undated facility policy, titled, "Sanitizing Your Thermometer," indicated, "...Proper sanitation of thermometers is imperative to avoiding cross-contamination and keeping food safe...Wash the			

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	thermometer by hand in hot soapy water; do not immerse it in water. after washing and rinsing the thermometer, sanitize it by hand using an alcohol based sanitizing wipe...Use an alcohol based sanitizing wipe between measuring the temperatures of different foods to clean the thermometer stem and avoid cross-contamination of foods...." The "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENTS," effective November 13, 2004, indicated,"...Sec. 136. (a) Except as specified in subsection (b), an employee shall chew gum, eat and drink food, or use any form of tobacco only in designated areas where the contamination of : (1) exposed food ...cannot result...Sec. 177. (a) Except as specified in subsections (b) and (c), food shall be protected from contamination by storing the food as follows: (1) In a clean, dry location (2) Where it is not exposed to splash, dust or other contamination ...Sec. 191 (b) Except as specified in (d) and (e) of this section, refrigerated, ready to eat, potentially hazardous food prepared and packaged by a food processing plant, shall be clearly marked, at the time the original			

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	container is opened in a retail food establishment and if the food is held for more than twenty-four (24) hours to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time conditions specified in subsection (a) and: the day the original container is opened in the retail food establishment shall be counted as day one (1); and (2) the day marked by the retail food establishment may not exceed a manufacture's use-by-date if the manufacturer determined the use-by-date based on food safety .... " Sec. 192 (a) A food specified in section 191 (a) or 191(b) of this rule shall be discarded if it: ... (3) is appropriately marked with a date or day that exceeds a temperature and time combination as specified in section 191 (a) of this rule ....Sec. 439 (a) Poisonous or toxic materials shall be stored so they cannot contaminate food, equipment, utensils, linens, and single-service and single-use articles by ...locating the poisonous or toxic materials in an area that is not above (A) food .... " 3.1-21(i)(3)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to	F0441	1. Residents 31, 44, and 50 was unaffected by the alleged	12/30/2012

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	follow infection control practices related to lack of hand washing [Resident #31], inappropriate delivery of clean linen, and inappropriate handling of clean linen during random observations. In addition, the facility failed to properly sanitize 2 of 3 glucometers during observation of blood glucose monitoring. This deficient practice affected 2 of 3 residents observed for blood glucose monitoring. [Residents #44 and #50] Findings include: 1. On 11/28/12 at 10:30 A.M., RN #23 was observed sneezing into her hands then immediately observed repositioning Resident #31. RN #23 was not observed to perform hand hygiene after sneezing or before direct resident care with Resident #31. On 11/29/12 at 10:18 A.M., the Director of Nursing provided "Handwashing and Hand Hygiene" dated 10/11. The policy and procedure included, but was not limited to, "Objective: To prevent and control the spread of infectious disease... Appropriate 20 second handwashing with antimicrobial or nonantimicrobial soap		deficient practice. 2. All staff have been in-serviced by the Director of Nursing and/or designee on infection control policies and procedures which included the proper handling of linens, handwashing and cough ettiquette. Nurses and QMA's have been in-serviced by the Director of Nursing and/or designee on the Glucometer policy and procedure. 3. All staff have been in-serviced by the Director of Nursing and/or designee on infection control policies and procedures which included proper handling of linens handwashing and cough ettiquette. Nurses and QMA's have been in-serviced by the Director of Nursing and/or designee on the Glucometer policy and procedure. On-going education will be provided for non-compliance and new employee orientation by nursing administration. 4. Audit will be conducted by Director of Nursing and/or designee on infection control which will include proper handling of linens, handwashing and cough ettiquette on a weekly basis times 6 weeks and monthly times 5 months. Audit will be conducted by the Director of Nursing on the cleaning of the Glucometer by the weekly times 6 weeks and monthly times 5 months. The audits will be reviewed by the Quality Assurance Committee	

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	and water must be performed under the following conditions... before and after direct contact with residents, when hands are visibly dirty or soiled..." 2. On 11/26/12 at 11:00 A.M., clean laundry was observed in a cart and being delivered by a staff member. An open can of soda and an open small bag of food was observed at the bottom of the cart next to the clean linen. 3. Observation was made on 11/30/12 at 1 p.m. in the on wing 1 of laundry personnel handling clean linens by placing them up against her personal clothing and then placing the linens on the clean linen cart. 4. Resident #44 was observed on 11/30/12 @ 10:56 a.m. during an accu check observation with a glucometer. LPN #14 was observed to lay the glucometer on top of the med cart half of the glucometer was on a blood pressure cuff and the other half on the top of the cart while she washed her hands. LPN #14 then placed glucometer in the top right hand drawer of the med cart without disinfecting it first. When asked if she was going to disinfect the glucometer, she said, "I should have done that before I put it away" and LPN #14 got			

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	the glucometer machine out and wiped with a disinfectant wipe, and let it air dry. 5. Observation was made of RN #15 on 11/30/12 at 11:28 a.m. during an accu check with a glucometer on Resident #50 to check her blood sugar. RN #15 was observed to not wash her hands prior to leaving the resident's room. RN #15 carried the glucometer and placed on the nurse's station desk while waiting on disinfectant wipes. RN #15 indicated she usually cleans with the disinfectant for 15-20 seconds and then allows it to air dry. RN #15 was observed once the wipes were available, wiped the glucometer with the disinfectant wipe for about 30 seconds laid back down on nurse's station desk to dry and then placed the glucometer on top of med cart. 6. Review of the facility's policy on Handling of Clean and Soiled Linen dated 10/06 indicated the "Purpose: Prevent the spread of infection." The policy indicated, "Clean linen will be handled in a manner that prevents contamination i.e.: away from body, placed on clean surfaces in the resident room. Clean linen will be transported from laundry covered carts. Linen carts will be covered...."			

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	Review of the facility's policy on Cleaning of Blood Glucose Meter with revised dated of 05/13/2010 indicated, "Purpose: Prevent transmission of blood borne pathogens." The policy indicated, "Blood glucose meters are to be cleaned after each patient use by wiping the meter with disinfecting wipes. The disinfectant wipe must remain on the meter for five minutes, allowing to air dry. Disinfecting wipe must meet EPA disinfecting standards. Wipes are to be used one time and then discarded. If the meter is excessively soiled, replace with a new meter. If patient is diagnosed with HIV, Hepatitis B virus (HBV) or other infections where it is not conducive to the sharing of blood glucose meter, a designated meter may be assigned to that patient." 3.1-19(g)(2) 3.1-18(b) 3.1-18(l)			

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F0463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure resident call light systems were in proper working order for 4 of 40 residents observed for proper call light system function. [Resident #64, Resident #56, Resident #22, and Resident #14] Findings include: 1. Observation on 11/27/12 at 10:08 a.m. of Resident #64's call light in her bathroom was observed to not be functioning in the hallway when turned on. Interview with LPN #14 verified the call light did not light up in the hallway, but does at the nurse's station even though the hallway light is impaired. Resident #56's call light was observed on 11/26/12 at 11:50 a.m. and was observed not functioning when turned on in the bathroom and observed to not light up in the hallway.	F0463	1. Residents number 64, 56, 22, and 14 call lights were repaired at the time of observation. 2. All residents call lights were tested and no other lights were found to be malfunctioning. 3. Maintenance staff was in-serviced by the Administrator on Resident Call light Policy and Procedure. 4. Resident call lights will be tested on a weekly basis for 6 weeks and monthly times 5 months. The audits will be reviewed monthly by the Quality Assurance Committee.	12/30/2012

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	Resident #22's bathroom call light was observed on 11/27/12 at 2:17 p.m. to not be functioning in the hallway when turned on in the bathroom. Resident #14's bedside call light was observed not functioning on 11/27/12 at 9:26 a.m. The charge nurse was informed who went to the room and checked the call light and a maintenance repair was requested per charge nurse. 2. On 11/29/12 at 10:00 A.M., environmental tour of the facility was initiated with the Administrator and the Maintenance Supervisor. At that time, in an interview, the Administrator indicated the nonfunctioning call lights were checked and fixed. He indicated all that needed done was to push the cord back into the socket on the wall. He indicated the call system was checked weekly and there had been no complaints or reported problems with any resident rooms or restrooms. The facility did not have documentation of the weekly checks. 3.1-19(u)(1) 3.1-19(u)(2)			

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